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No. 85-1385

In the Supreme Court of the United States

OCTOBER TERM, 1986

UNITED STATES OF AMERICA, PETITIONER

v.

GENERAL DYNAMICS CORPORATION, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

REPLY BRIEF FOR THE UNITED STATES

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1. Pursuant to its collective bargaining agreements, respondent reimburses its employees for some of their medical expenses, but not until all of the following events have occurred: 1) an employee receives and is charged for covered medical services; 2) the employee files a claim for reimbursement supported by the appropriate documentation; and 3) respondent processes the claim and approves all or part of it for payment. For federal income tax purposes, however, respondent contends that the first step in this series of events—the receipt of covered medical services—is the final event that "fixes" and creates a definite obligation to make reimbursement. Hence,

respondent contends that it was entitled to deduct $5.5 million on its 1972 tax return as an expense "incurred" during that year (I.R.C. § 162) for amounts that respondent estimated (based on past experience) that it would be required to pay in future years for employee medical services that were received in 1972, but for which claims either had not been filed or had been filed but not yet approved during that year. Thus, although the filing of a claim by the employee and processing and approval of that claim undisputedly are treated by respondent as conditions precedent to payment, respondent maintains that these conditions can be ignored for tax accounting purposes and therefore that the "all events" test (Treas. Reg. § 1.461-1(a)(2)) does not prevent it from accruing a deduction for payment of medical expenses before employee claims for those expenses have been filed or approved.

Respondent reaches this counterintuitive legal conclusion primarily by *ipse dixit* (see Resp. Br. 5, 17-18). The one reason given is the fact that once an employee has incurred covered medical expenses, respondent loses the ability to avoid reimbursement liability by terminating the plan (see Resp. Br. 17). It is true, of course, that at that point the employee has obtained a right *to seek reimbursement* under the plan; therefore, respondent may well have lost the ability to avoid a potential liability by its own unilateral action. But that is not the same as saying that a fixed and definite liability has arisen. Any potential liability that has arisen as a result of the employee's doctor visit is uncertain and contingent until the occurrence of two future events—the filing of a claim and the processing and approval of all or part of that claim. It is only after the completion of

these two additional steps, which may in any individual case be time-consuming or quite simple, that respondent acknowledges any liability to reimburse a particular employee for particular medical services, and until that time its potential liability for such reimbursement is not sufficiently definite to be accrued under Section 162.

This is not to deny that it is highly probable that many of the covered medical expenses incurred in 1972 will ultimately be claimed by employees and reimbursed by respondent. But the "all events" test is not satisfied by a high probability that obligations will become fixed in the future. "Financial accounting * * * is hospitable to estimates, probabilities, and reasonable certainties; the tax law, with its mandate to preserve the revenue, can give no quarter to uncertainty." *Thor Power Tool Co.* v. *Commissioner*, 439 U.S. 522, 543 (1979).[1]

2. We contended in our opening brief (at 35-36) that an unconditional obligation to make a payment

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[1] The indefinite nature of this potential liability is highlighted by the method that respondent must use to compute the amount of its reserve for incurred-but-not-reported claims. Respondent has no knowledge of any facts respecting any particular employee or doctor visit; instead, it bases its reserve on an aggregate estimate of future liability that is statistically derived from past experience. Such an aggregate statistical estimate is incompetent as a matter of law to establish "the fact of the liability" as required by the first prong of the "all events" test. By contrast, the cases on which respondent relies to support its accrual theory all involved deductions that were premised on actual facts known to the taxpayer at the close of the tax year, not merely on statistical projections based on prior years. See, *e.g.*, *United States* v. *Hughes Properties, Inc.*, No. 85-554 (June 3, 1986); *United States* v. *Anderson*, 269 U.S. 422 (1926).

to an employee cannot possibly arise until that employee files a claim for reimbursement. Respondent does not dispute that, if no claim is filed, the plan does not oblige respondent to make any reimbursement for covered medical charges, and in fact respondent does not make any payment in those circumstances. For that reason alone (see Gov't Br. 38 n.13), respondent's attempt to accrue a deduction in 1972 for the estimated amount of medical charges incurred in that year, but for which claims had not yet been (and might never be) filed, manifestly fails the "all events" test.

Respondent makes little effort to answer this contention. It lamely states that "[t]here is no evidence that any significant number of employees failed to file claim forms" (Resp. Br. 13). Of course, the burden is on respondent to establish its entitlement to the deduction it seeks (*Helvering* v. *Taylor*, 293 U.S. 507, 514-515 (1935)); the government has no responsibility to demonstrate the extent to which employees ultimately fail to comply with the precondition to reimbursement established by respondent's plan—a negative statistic that probably cannot be determined. The point of the "all events" test is to eliminate the need for such "conjecture" (Resp. Br. 18) by prohibiting the accrual of expenses until *all* the conditions necessary to fix the obligation have been satisfied; in this case, those conditions clearly include the filing of a claim. At any rate, there is no dispute that at least some eligible employees fail to claim reimbursement for covered medical services,[2] even though the extent of such failure to file

[2] Respondent does not assert that all eligible employees claim reimbursement for all their covered medical services; it disputes only the notion that the number of employees who fail

claims may not be known. Therefore, it is manifestly premature for respondent to take a deduction for medical charges incurred by employees, but for which no claim for reimbursement has been filed.

Respondent also contends (Br. 18-21) that the fact that employees sometimes do not claim reimbursement for medical expenses does not mean that respondent did not have an unconditional obligation to make that reimbursement at the time the medical services were rendered; rather, respondent characterizes the failure to file a claim as "a waiver of an already accrued right to benefits" (Resp. Br. 18). This contention is plainly mistaken. It is true, of course, that it is possible for payment to be waived when there is a fixed obligation to pay, such as when a creditor forgives a debt. But that is not the situation here. There is no obligation on respondent's part to make a payment until the employee files a claim. Until that time, the employee has no basis for demanding payment, and he clearly could not prevail in a lawsuit seeking to collect reimbursement from respondent. By failing to file a claim, he is not forgiving an existing obligation to pay; rather, he is failing to take a step that would lead to the creation of such an obligation.

3. Respondent contends (Br. 15-16) that there is no legal issue for this Court to resolve; it argues that the "findings" of the trial court and the record in this case conclusively establish as a factual matter that respondent had a fixed and definite obliga-

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to do so is "significant" (Resp. Br. 18) or "substantial" (Resp. Br. 16). The record does not address this precise issue, but it does establish that employees sometimes file their claims later than the time limits specified in the plan, which prevents them from triggering an obligation on respondent's part to make reimbursement (see J.A. 130-131; Gov't Br. 36 n.11).

tion to make reimbursement at the time covered medical services were rendered (see Resp. Br. 15-29). This is plainly incorrect. Based in large part on its reading of *Kaiser Steel Corp.* v. *United States*, 717 F.2d 1304 (9th Cir. 1983), which in our view was wrongly decided (see Gov't Br. 41 n.14), the trial court reached a legal conclusion that the events following the receipt of medical services that are preconditions to reimbursement by respondent are too insignificant to prevent accrual of a deduction for the medical expenses; rather, the court concluded, "the fact of *injury* established the fact of *liability*" (Pet. App. 13a (emphasis in original)). The court made no findings of fact that would compel a judgment in respondent's favor under a correct legal analysis of the case.

The record simply does not support the weight that respondent would place on it. Respondent asserts (Br. 16) that the record establishes that "claims processing is clerical and ministerial" and "claims are not contested"; it also states that there is no evidence that any substantial number of people do not file claims. If anything, the record is directly to the contrary. As pointed out above (note 2, *supra*), the record establishes that some claimants fail to take advantage of their right to reimbursement by filing a timely claim. And, while there may be some dispute about the extent, the record clearly establishes that some benefit determinations are contested.[3]

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[3] Various figures were put forth in the testimony in the trial court concerning lawsuits brought to challenge benefit determinations. Aetna reported 229 suits regarding the issue of prevailing rates alone (J.A. 116-117) and 199 suits in 1982 and 129 suits in 1979 on other issues (J.A. 135). Prudential reported 96 suits in 1982, and two suits that the witness person-

In stating that the computation of the allowable reimbursement is "ministerial," respondent would have us believe that its plan is so detailed and precise that the calculation of benefits under the plan is like using multiplication tables—*i.e.*, that different claims processors would invariably arrive at the same benefit figure for the same claim and that the employee would have no basis for disagreeing with that determination (see Resp. Br. 23). We have no doubt that this may be true for the simpler claims and, indeed, for the majority of claims. But it plainly is not true across the board that respondent's plan leaves no room for uncertainty or dispute with respect to any benefit determination.

The possible pitfalls of a benefit calculation are illustrated, rather ironically, by a simple example given by respondent in its brief of a claim that could be "processed routinely in a few minutes" (see Resp. Br. 22-23). In respondent's example, the plan provides a $60/day maximum for hospital room charges, and the employee is charged $70/day for three days. Respondent explains that the employee—once he files a claim—is clearly entitled to reimbursement only of $180 and would know from reading the plan that the excess $30 was not reimbursable. Perhaps that is clear as day, and perhaps respondent is right that if this claim "were submitted to several different processors, they would reach the same result" (*id.* at 22). But it bears mentioning that if this claim had

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ally recalled going back to 1972 involving respondent (J.A. 171-172). As we noted in our opening brief (at 37 n.12), because of the relatively small sums that are usually at stake, one would expect the number of lawsuits challenging benefit determinations to be dwarfed by the number of contested claims that do not result in litigation.

been presented to respondent's Director of Employee Benefits, who testified at trial as to the operation of respondent's plan, he would have reached a different result—authorizing payment of $204 reimbursement by crediting the excess $30 at 80 percent (see J.A. 92).

The record demonstrates that the plan contains other ambiguities that necessitate the exercise of judgment by the claims processor—judgment that may legitimately be challenged by the employee. The claims processor may be called upon to decide whether a condition "may be judged chronic" (J.A. 128), whether a prior course of treatment is sufficiently related to a claim to justify denial on "pre-existing condition" grounds (J.A. 129), or whether "extenuating circumstances, like getting [the doctor] out of bed at 3 o'clock in the morning," justify a higher fee (J.A. 124). The record emphasizes respondent's need to have the opportunity to "evaluate" and "investigate" claims (J.A. 131), and respondent in its brief (at 8-9) lists various circumstances in which the claims processor would have to solicit further information from the employee's doctor before deciding upon the proper reimbursement. These facts hardly accord with respondent's characterization of the benefit-determination process as plugging numbers into a simple formula. In sum, there is a sufficient degree of uncertainty in the benefit-determination process that the step of approving the claim (which, after all, respondent views as critical to making its own decision to pay) cannot be dismissed as "ministerial" and thereby be ignored for purposes of applying the "all events" test.

4. Respondent mischaracterizes our position in stating that our view of the case is "call it a 'reserve' and the government wins" (Resp. Br. 39).

This case does not turn on semantics. Clearly, a taxpayer may set up an account reflecting expenses that have properly accrued and label it a "reserve" without losing the right to deduct the accrued amounts. But Congress quite clearly has provided that a taxpayer generally cannot claim a deduction under the accrual method of tax accounting for the typical type of reserve—one set up for financial accounting purposes to reflect a probabilistic estimate of future liabilities that are not presently fixed. The fact that respondent's IBNR reserve is precisely this type of reserve account—computed not by reference to any known facts concerning the potential liability, but rather solely as a statistical estimate based on past experience—is thus highly probative. When one considers that respondent quite literally took the IBNR reserve off the books of its insurance companies and placed the reserve on its own books, that Congress found it necessary to enact special provisions enabling insurance companies to deduct such reserves (see Gov't Br. 23-29), and that Congress enacted and then quickly repealed legislation that would have allowed other taxpayers to deduct such reserves (Gov't Br. 19-22), that Congress did not contemplate that such reserves could be used by ordinary taxpayers to accelerate deductions under Section 162.

For the foregoing reasons and those stated in our opening brief, the judgment of the court of appeals should be reversed.

Respectfully submitted.

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